**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH**

JUVENILE JUSTICE TRANSITION AFTERCARE SERVICES (JJTAS)
TREATMENT, REFERRAL AND AUTHORIZATION FORM

# Email completed form to: jjtas@dmh.lacounty.gov

***Referral to be completed by DMH staff only – 45 days prior to Transition MDT. Referrals only accepted via email above.***

| **Referral Source** | | | |
|---|---|---|---|
| **Name:** | **Title:** | **Phone:** | **Email:** |
| | | | |

| **Client Information** | | | |
|---|---|---|---|
| Client Name: | | DOB: | |
| Race/Ethnicity: | | Preferred Language: | |
| Gender: | ☐ **Male** ☐ **Female** | Social Security Number: | |
| Insurance (if known): | ☐ **Medi-Cal** ☐ **Health Families** ☐ **Private** ☐ **None** ☐ **Other:** | | |
| **Post-Camp Placement:** | | | |
| Home Address: | **City:** **Zip Code:** **Phone:** | | |
| Contact Person: | | Telephone Number: | |
| Relationship to Client: | | | |
| Client is Emancipated Minor: ☐ No ☐ Yes | | Date of Emancipation: | |

| | | | |
|---|---|---|---|
| Name of Camp: | | Camp Admission Date: | |
| Transitional MDT Date: | | Projected Release Date: | Early Release Date: |
| **DMH Camp Clinician:** | **Phone:** | **Email:** | |
| **Camp DPO:** | **Phone:** | **Email:** | |
| **Field DPO:** | **Phone:** | **Email:** | |

| **Other Agency Involvement** | | | |
|---|---|---|---|
| ☐ **DCFS** | **Contact Name:** | **Phone:** | **Email:** |
| ☐ **Other:** | **Contact Name:** | **Phone:** | **Email:** |
| ☐ **Other:** | **Contact Name:** | **Phone:** | **Email:** |
| ☐ **Other:** | **Contact Name:** | **Phone:** | **Email:** |

Client Name: _____

DMH IS#: _____

PDJ#: _____

## Clinical Issues/Treatment Needs

**Please check any that apply and provide details where space is provided:**

- ☐ Depression
- ☐ Violence (i.e. home, gang, domestic violence, etc.)
- ☐ Substance use
- ☐ Child Welfare involvement (past or present)
- ☐ Family conflict
- ☐ Limited interpersonal, social and coping skills
- ☐ Impulsiveness
- ☐ Trauma (i.e., experienced, a threat, witnessed, etc.)
- ☐ Anxiety

☐ Medical (i.e., medication needs, mental health.):

_____

_____

☐ Brief Overall Clinical Impression (i.e. symptoms, behaviors, strengths and impairments):

_____

_____

_____

_____

M.H. and/or Substance Abuse Referrals Made Date Sent

_____

_____

_____

_____

**Recommend:**

Court Mandated Treatment

- ☐ Family Functional Therapy (Family Therapy)
- ☐ Seeking Safety (Group Therapy)
- ☐ Aggression Replacement Therapy (Group Therapy)

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date Received: | | Received By: | | Supervisor Assigned | | Date: | |
| Clinician Assigned: | | Date: | | Initial Screening Date: | | Location of Screening: | |

**Screening has been completed with the following recommendation:**

- ☐ Client accepts JJTAS services
- ☐ Client declines JJTAS services
- ☐ Client accepts services; has been linked to the following agencies:

1. *Name of Agency:* _____ *Reason for linkage:* _____
   *Contact Person:* _____ *Title and Phone No:* _____
   *Date of 1st appt:* _____ *Memo:* _____

2. *Name of Agency:* _____ *Reason for linkage:* _____
   *Contact Person:* _____ *Title and Phone No:* _____
   *Date of 1st appt:* _____ *Memo:* _____

3. *Name of Agency:* _____ *Reason for linkage:* _____
   *Contact Person:* _____ *Title and Phone No:* _____
   *Date of 1st appt:* _____ *Memo:* _____